Asylums:
the historical perspective before, during, and after

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Readers thinking about mental healthcare in todays developed world probably envisage clinics and hospitals funded by the state, providing in- and out-patient treatment. But as late as the 1750s there were just three public asylums in England and one each in Scotland and Ireland, housing at most 400 of what were then termed 'lunatics', in a population of 7 million; roughly the same number were in private madhouses. In 1800, when the UK had about 11 million inhabitants, no more than 5,000 people were in mostly small public and private lunatic asylums.[1] Virtually all care of the mentally disordered was in some sort of domestic setting. Many sufferers were 'at large', in the rhetoric of late-Georgian social reformers, implying neglect and failure. A century and a half later, institutionalisation had reached its peak. Some 150,000 people resided in UK asylums in 1954, a rate per head of population nearly 7 times greater than 1800. At that date half of all NHS hospital beds were given over to patients with mental illness or impairment. Numbers fell thereafter to 50,000 by 1990.[2]

Consciously or otherwise, perceptions of the here and now are based on conceptions of the past that may be one-dimensional at best and misguided at worst. In particular, the mental map of asylums past is drawn in sharply contrasting colours - humanity v. barbarity, knowledge v. ignorance, good practice v. bad – which do not allow for the shades created by the ideological and cultural context in which different locations and types of mental healthcare have been provided over the last two centuries. That context has been afforded by two generations of historians of medicine.[3] Their work has nuanced the standard narrative about the history of asylums by taking into account the voices and views of those who were in them at different historical time points. Thus the argument of this article is twofold. First, to caution against dismissing inpatient care outright, as simply a failure of the 'bad old days', but to look at everyone's experiences of it and ask what current mental health systems can learn from its successes and failures. Second, to illustrate the ideological background to many structures and changes, which might superficially seem merely clinical and instrumental.

Historiography of the asylum: from top-down to bottom-up approaches

It is simplest to expose the influence of ideologies by looking at historiography, which is the history of how and why historians, as both individuals and 'schools', approach their subject.[4] The prevailing narrative of asylum development in the mid-20th century is exemplified by Kathleen Jones, whose work still features among RCPsych recommended reading. With its origins in traditional Christian Evangelism and Liberal Reformism, practical knowledge of asylums (her husband was chaplain to one), and the optimism of the early Welfare State, Jones' work is an account of progress in both psychiatric science and state intervention. For Jones, asylums saved the insane from neglect and abuse; they were a thoroughly good idea that went badly wrong and from the consequences of which provision has never recovered.[5]

Jones' first book came out in 1955. It exemplifies how top-down was the history of psychiatry done by academic historians or clinicians-turned-historians: writing up case notes, medical biographies or institutional and legislative studies. Published (in French) not long after (1961), Michel Foucault turned the usual story of improvement on its head, arguing that the mad were treated worse in the modern age, than in the Middle Ages. The Enlightenment of the 18th century, he argued, ended a medieval dialogue between madness and sanity, allowing reason to triumph and the mad to be classified and dehumanized by subjecting them to medical discourses.[6]

Jones and Foucault have completely different intellectual roots and different sorts of top-down approach, but they share ideological clarity. Foucault was not an historian and his text has remarkably few facts; even those can be interpreted in quite different ways than he does. Curiously, he is like the early reformers and psychiatrists about whom he writes so obliquely, acting largely without evidence, but with certainty to spare. Jones' optimism, on the other hand, came from an idealisation of both asylums and the state, albeit better grounded empirically.

Equally value-loaded is the generally pessimistic interpretation of many sociologists. For this discipline in particular, there is a seductive simplicity in equating the asylum 'movement' with major changes in society, such as the rise of the bourgeoisie, the triumph of capitalism, or the emergence of a psychiatric profession, and to see institutions as being as much about control as cure.[7] Much writing about patient care is of this top-down type, a narrative of 'makeshift provision' giving way to the darkness of incarceration before light re-emerged

with extra-mural care, albeit tainted, for Scull and others, by the spectrum of 'big pharma' making big profits by pushing unnecessary drugs.[8] Such studies are intellectually valid, seeking to answer the big 'why?' questions. Viewed from far enough away, grand Marxist-functionalist narratives are plausible enough, but they fall as far short as liberal-scientific ones in explaining where asylums came from, and how they worked both internally and with the constituencies they served.[9] Like Foucault, sociologists tend to sacrifice the intractability of the parts to the integrity of the whole. Historians, in contrast, look at those very parts, at the agency of people and their context, to derive a picture that more closely represents what may in fact have happened.

Foucault came out of, and helped to shape a new approach to medicine and society - and relations between them – from the 1960s, reconceptualising both the representation of mental disorders in the public sphere and perceptions and practices of professional psychiatry. The transfer of mental health care from institution to community was, for example, accompanied by a new 'recovery model' for sufferers, which emphasised economic independence and personal autonomy.[10] Feminist critiques of both traditional sources of authority and assumptions about the biological bases of difference in general, and in mainstream psychiatry in particular, were especially powerful, laying the foundations for greater assertiveness about women's mental healthcare inside and outside institutions.[11] Yet beyond this, many local initiatives in community mental health care were not explicitly 'anti-psychiatry', but instead intended to fill a gap in provision by blending medical inputs with holistic approaches that situated individual sufferers in specific social and material environments.[12] These were just part of the extraordinary variety of non-institutional responses to changing priorities and needs, appearing from the 1960s onwards.

This points us to the benefits of an evidence-based, bottom-up approach to institutionalisation and deinstitutionalisation in the last two centuries. 'History from below' gained currency from the 1950s, putting ordinary people front and centre. For the history of medicine, this meant taking the patient's perspective (as well as that of nursing staff, volunteers, and families) and also looking at local experience to see if it would be possible to verify, modify, or reject overarching theories of change. A 'culture of fact' that embraced law, history, and religion as well as science may have existed since the seventeenth century in Britain, but the evidential basis of psychiatry has been built only slowly and intermittently

since then.[13] Psychiatry's standing has been highest in periods when it linked medical authority with medical evidence. The early 19th century emphasis on neurophysiology - the brain as the organ of mind - was one such period, revived in the current generation's focus on neuroscience. The same is true of the history of psychiatry, which is strongest when it is based on documentation, examines the agency of all involved parties, and is alert to the non-medical context in which many clinical debates and events were located.

Georgian origins of modern inpatient care

The 1810s offer a starting point because the decade is well known for the scandals thrown up by early official investigations into asylum provision at Bethlehem Hospital and elsewhere, conventionally part of the darkness to light narrative. One dispute erupted at York Lunatic Asylum (opened in 1777), which shows that material provision of institutional places and changes in governance were not simply a victory of humanity over inhumanity, good practice over bad. Apparently about supervision of medical staff and attendants, events at York 1813-15 show how reform of lunatic asylums relates to wider social, cultural, and political forces. A battle over the administration of York Asylum was in fact a clash between different conceptions of social power and public accountability, which were rooted in the utterly different ideologies of 'county' gentry (Tory, later Conservative) v. evangelical middle class (Whig, later Liberal). In turn, the outcome profoundly affected the subsequent social identities of medical practitioners who cared for the mad, requiring them to rely on the authority of science rather than the dominance of class.[14] Similarly, the separate Retreat at York (opened in 1796) is a testament to the wealth and sense of identity of middle-class religious dissenters (Quakers), as much as it is to their humanity.

Reflecting a union of economic individualism and social corporatism, the voluntary model of asylum foundation evidenced at York and elsewhere strongly influenced the development of English county asylums as they began to be built in numbers after 1845.[15] Writing of greater London's pauper 'farms' (actually large buildings) c.1800, Murphy argues that private and voluntary asylums were not superseded by public until well into the Victorian era: 'The mixed economy of care remained fluid and susceptible to local economic and cultural forces long after the 1845 act.'[16] Emerging from the 1870s onwards, after-care bodies were largely staffed by volunteers (and based around churches) and unpaid helpers again became

prominent in the 1960s and 1970s, responding spontaneously to local needs without any central direction.[17] While chronically straitened in circumstances, their contribution remains important, even if the fragmentation and multiplication of bodies around often narrow issues has detracted from the coherent part the sector might have played in structuring change.

The rise of Georgian asylums funded by voluntary subscription came from a desire to help middling rank families out of the 'poverty trap' that lay between parish-supported or 'Poor Law' care and expensive private madhouses, and was thus the result of the same social and political change which brought about The Representation of the People Act (1832). Most of the well-known social-welfare legislation of the 19th and early 20th century was passed by Whig or Liberal administrations; Wynn's County Asylums Act (1808) is a good example, though permissive rather than obligatory. Prominent reformers were from both ends of the political spectrum, but their inspiration came out of Whig ideologies of state intervention and societal improvement.[18] At the level of micro-politics, the opponents of building county asylums, even after legislation made them compulsory in 1845, were usually Tories averse to central control and taxation, which they saw as curtailing their fundamental rights.[19]

The point is that psychiatric change may have been the product of psychiatrists and shaped by legislators, but it could also be an expression of the values of a group within civil society: a product of politics. In a secular age we tend, in particular, to forget how important religion was in articulating a person's mental problems and in implementing 'talking therapies'. It was also a leading force behind campaigns to end the slave trade and then slavery itself in the British Empire. Progressive ideas on the treatment of the mentally disordered were more likely to come from evangelical Christians.[20]

The public and private faces of asylums

What were the resulting asylums like? If we believe their modern critics, like sociologist Erving Goffman, they were 'total institutions': closed, controlled, and controlling, where the rights of patients were subordinated to professional interest and societal requirements[21] Again, research since Goffman has largely discredited this broad-brush picture, even if it has also shown that institutions were never without their detractors. In their study of four

different asylums in Devon, Melling & Forsyth exemplify the best of modern approaches 'from below', arguing that 'the asylum can be seen as a corridor between civil society and the state along which different groups met to negotiate'. They explore 'the micro-politics of the Poor Law and the specific family strategies, which surrounded the dispatch to and from the asylum' and 'locate these relations within a changing world of class, gender and inter-generational relations'.[22]

Until the twentieth century, admission to an institution normally arose from a petition drawn up either by family members or someone in a position of authority such as a clergyman or magistrate, setting out evidence that a person was mad. From the sufferer's viewpoint, admission was involuntary. Admission petitions often state that symptoms had been evident for months or even years before the application, telling us that even when many more asylum places were available, there must have been considerable complementary 'care in the community' before admission and after discharge. After all, a phrase (now used with great caution) can mean: linked to existing mental hospitals (aftercare tied to asylums or general hospitals); outpatient care in institutions run by private or charitable agencies; provision by local authorities, using social workers, OTs, and others; patients living in communities, looking after themselves with the help of family and neighbours.[23] The kind of asylum or 'place of refuge' a person needs varies enormously depending on the contingencies of their lives, which includes their mental health, but also the financial and other circumstances of their families, the availability of external support, and the attitudes of communities to their behaviour.

Asylums were permeable institutions, both in the sense that patients could be admitted, discharged, and re-admitted, and in the way asylums were influenced by, and also affected, their social and political environment. There was, for example, growing external regulation of English asylums from the 1860s and more so as the advent of county councils in 1888 brought them onto the radar of regional as well as local and national authorities, culminating in the Lunacy Act (1890). Annual asylum reports show a keen awareness of the importance of public opinion to their running, using prevention of suicide as one indicator of a caring and controlled environment. Meanwhile patient newsletters performed a similar function by stressing the normality of institutional life.[24] Asylum operation depended on the relationships between central and local political entities, law courts, welfare authorities,

medical personnel, communities, and the patients' families (especially important at admission and when discharge was imminent). As late as 1890 families and communities were the main guardians of those with mental disorders, in their helplessness and distress. Since then, the rights of individuals to liberty have been increasingly prioritised under the eye of the state, culminating in the present system of multi-layered legal and bureaucratic oversight of the rights of patients and the obligations of practitioners.

The better off could more easily sign themselves in for 'rest cure' in private clinics, safe from the stigma of certification and the trauma of involuntary confinement. In existence since at least the 17th century, private madhouses were mostly for rich people, featuring high staff/patient ratios and facilities more reminiscent of a country house hotel than an asylum. Think Priory, whose flagship Ticehurst property was a family-run madhouse between 1792 and 1917.[25] Private madhouses nevertheless had an image problem. In the interests of confidentiality, many families supported private keepers' resistance to government inspection, just as they opposed the mixing of classes of patients in the new public asylums. However, the allegations of lunacy reformers from the 1850s onwards about venality and poor standards combined to undermine private provision. Abundant places in new public asylums aimed mainly at paupers allowed some older (usually endowed) ones to turn towards private patients over the 19th century. Bethlehem Hospital is an example.[26] The seven Scottish royal or chartered asylums opened 1781-1839 went down the same road after 1857. Private commercial provision withered away in the early 20th century. Nowadays, in contrast, NHS MH provision could not function without private and voluntary provision, barely visible though some of it is.

Media-aware as public asylums were, they too had their critics as early as the 1850s. Alexander Morison, physician to Bethlehem Hospital and elsewhere, expressed a concern felt by his fellow Scots and the Welsh alike about the importance of a balanced provision that included domestic care, when coping with the mentally disordered or handicapped. The Scottish preference for out-relief in a family home is shown by the locations where the mentally disabled were housed. In 1867 twice the proportion (nearly 30%) were cared for in a domestic setting compared with England.[27] An example is the extensive lodging of the chronically insane and 'feeble-minded' in the private houses of farmers in the countryside

around Glasgow, and on the Isles of Arran and Bute, documented in the decadal censuses of population.[28]

This emphasis on non-institutional care is important because it shows enduring cultural differences in provision across regions of Britain. The Welsh too favoured domestic care and large-scale institutionalization did not begin until the early 20th century in Wales, where 'the nexus of cultural, social, religious, familial and linguistic links was fundamental to the support systems of social care'.[29] By contrast, intra-mural care in Ireland was far more prevalent than in England: the highest rate in Europe by 1900. Central government played a much more direct role in 19th century Irish asylums than in the rest of the United Kingdom, the result of the colonial style in which Ireland was governed. Between 1867 and 1945 half of committals were under the Lunacy (Ireland) Act, which allowed magistrates to send apparently dangerous people directly to asylums at the expense of the state. The kind of debates that informed legislation elsewhere in the UK did not extend to Ireland, which did not adopt the main British enactments of that period. Ireland was socially quite different too, with limited private provision or public-subscription establishments (though religious orders provided charitable services), no formal Poor Law until 1838, different (Catholic) social thought, and a deeply polarised society with extensive rural poverty.[30]

MH professionals still work within parameters created by such historic differences. During the 1970s Scotland had double the English rate of in-patient care and the process of deinstitutionalisation was even more hesitant and irregular than England between c.1960 and 1990.[31] This was a conscious choice rather than the result of inertia, the product of a long-established non-institutional ethos coupled with a more recent belief that properly located institutions should be the centre of provision.[32] In Scotland, where day-hospital places were unknown before the 1970s, ideologies of deinstitutionalisation helped reform institutions in a country with a distinctive history and culture. Scots had long preferred local decision-making. Based on their historic experience of light-touch government prior to the 20th century, they felt that central authority could and should intervene for benign ends, but that most power should be diffused.[33]

The uneven road to reform

Within 19th century institutions movements for reform took root. Scottish asylums pioneered unlocked wards and they were the first in Britain to allow voluntary admission to public asylums from the 1860s.[34] The latter was formally sanctioned in England and Wales in 1890, but remained uncommon there until the Mental Treatment Act (1930). By the end of the nineteenth century Scottish asylum builders also rejected the increasingly large monolithic style of English institutions in favour of dispersed 'village-style' or 'garden-city asylums' where landscape and environment were part of a therapeutic process rooted in Enlightenment ideologies of individual freedom and improvement.[35]

Yet by Edwardian times many asylums truly were what Scull calls 'warehouses of the unwanted' or 'a convenient place to get rid of inconvenient people'.[36] From within them came more generalised critiques of purposes and methods across the United Kingdom. Dr Montagu Lomax, assistant medical officer at Prestwich Asylum near Manchester, described an overcrowded, inhumane, and ineffective regime of confinement, along with inactive, apathetic, and isolated patients.[37] The book had important implications for the reform of patient welfare, and for the recruitment and training of psychiatric nurses. Lomax's criticisms, like those of Morison, came out of psychiatry itself. His book stimulated attempts to make mental hospitals less 'institutional' and more patient-friendly, between the 1920s and the 1960s. As a result, all asylums started to become more domesticated, offering greater comfort, fewer barriers to movement, and a range of recreational facilities; altogether more homely. Yet Prestwich itself was slow to change, a reminder that institutions have lives of their own.[38] We might note in passing that only now are historians turning to nursing staff or 'attendants', who formed a much more central part of inmates' lives than did psychiatrists, in public asylums which each housed on average about 1,000 patients in the early 20th century.[39]

We privilege Lomax's opinion because, with hindsight, we know it was the way of the future. Totalitarian and anti-therapeutic, the subsequent demise of the asylum seems natural, an inevitable if overdue triumph of common sense over mistaken ideology. Yet his was not the only voice in the inter-war years. Prominent psychiatrist John R. Lord saw mental hospitals as 'rehabilitative, medical and humanitarian community-centred institutions'.[40] Where Lomax thought that publicity would reveal the unacceptable

manufacture of madness by institutions, Lord saw media representations as a barrier to public appreciation of what hospitals could do, when integrated with social work and aftercare under the direction of psychiatrists. In his scheme, patients and communities were the subjects rather than the agents of reform. Both viewpoints can be seen playing out in the development of care ever since.

Many psychiatrists still believe that a hospital environment is an essential part of cure and rehabilitation into society, allowing better observation (and thus diagnosis) and supervision of medication, psychotherapy, and access by psychiatric social workers and others. All in all, they argue, hospitals are valuable resources for protection and rest: a place where medical professionals can replace despair with hope. Hospital beds allow for respite admissions or for patients to ask for admission as part of a care plan, though usually for acute cases, potentially leaving a gap in provision for the chronically ill, who constitute most of the readmissions.

During the 19th century asylums made the psychiatric profession, which in turn began the reform of conditions within them and the spread of day-hospitals outside, especially in England. Between the 1960s and the 1990s (perhaps later) institutions nevertheless remained the focus of the profession for career development. Psychiatrists were no readier than any other body, to lead the hesitant and irregular march from intra- to extra-mural care.[41] Nor were medical professionals the only defenders of asylums. They were major employers and important contributors to the local economy, especially the ones in rural or semi-rural settings.

Further examples of the downside of downsizing are not hard to find. The closure of Victorian asylums removed a layer of secure care that might have been open to offenders with mental disorders, as a substitute for prison – which they were in Victorian times and after, when criminal lunatics ceased to be anomalies in both justice and health care. Asylums have not been replaced by adequate regional secure units and access to minimally secure hospitals, leaving penitentiaries with much higher rates of mental disorder than the general population.

Reforming asylums also involved changing their legal underpinnings. While we may see public asylums as an imperfect precursor of modern mental hospitals (as they were increasingly renamed in the inter-war years), they owed more in legal terms to the Poor

Law. In England local officials aimed to reduce cost by discouraging the use of facilities except as a last resort. It was not until the early 20th century that changes in social policy, such as the Liberal government's National Insurance Act (1911), led to the emergence of a differently conceived, centralised social welfare system that ultimately became the Welfare State. The changes in psychiatric provision encapsulated in the Mental Treatment Act (1930) – including early-treatment, voluntary-admission, and non-residential options – were based on existing examples of best practice, but without the Poor Law.[42] Slowly a system of specialised provision emerged. Yet the whole idea of an integrated system of care is itself an innovation of the twentieth century.

Historians of psychiatry often look to such legislative landmarks as an indicator of progress, but there were limits to standardization by statute law. For example, the apparent clarity of definition and terminology in the Mental Deficiency Act (1913) belies the enduring diversity of local practice in dealing with intellectual disabilities.[43] Yet there is no denying that the broader political climate was changing at mid-century, not only towards greater formality and uniformity. In 1961 the Conservative Minister of Health, Enoch Powell, spoke out strongly against old-style mental hospitals as symbolically and economically indefensible. Though it came as a bombshell to clinicians, Powell's speech was less radical than it sounds because English infirmaries had since the 1930s begun to establish out-patient psychiatric clinics and wards for acute cases, attached to their general healthcare provision. Nor was the effect immediate. Deinstitutionalization happened slowly, by reducing funding and gradually closing asylum wards. The real weight of New Right economizing measures only produced rapid change in the 1980s and 1990s.

Indeed, changes in asylums took place gradually for much of the 20th century, the spread of new approaches shaped by established ideas and practices. The therapeutic confidence, which accompanied 19th century physicalism and the legacy of Enlightenment optimism, waned towards its end. Clinicians became pessimistic about the possibilities of improving patients with learning disabilities and were unable to treat organic conditions like general paresis, which accounted for a fifth of adult male admissions c.1900.[44] This new attitude was part of a wider set of concerns about human degeneracy that fed into the eugenics movement, but it also came out of traditional assumptions about the underlying moral bases of social problems such as mental deficiency, sexually transmitted infections, and

alcohol or drug abuse.[45] Despite interludes such as psychosurgery in the 1930s and 1940s, psychotherapies and an emphasis on the social dimensions of care grew in importance.

Again, the roots of systematic psychosocial approaches are Victorian. The chaplain of Colney Hatch Lunatic Asylum north of London founded the Mental After-Care Association in 1879 (now 'Together') to support people leaving the institution and thus limit readmission. Formal training for psychiatric social work commenced in 1929 when a one-year mental health course opened at the London School of Economics. The Association of Psychiatric Social Workers began in the same year. Facilitating the social reintegration of patients following treatment, social workers' role became increasingly important from the 1960s, helped by new and effective medications available to prescribing physicians – though the adoption of drugs may have owed as much to professional and commercial imperatives as to scientific ones.[46] Demographic transformations made holistic approaches a practical necessity. Increasing adult life expectancy in the 20th century meant that by 1971 nearly half the patients in mental hospitals were aged 65 or over, focusing minds on old-age psychiatry and emphasising the need for a spectrum of ancillary services such as occupational- and physio-therapists.[47]

People

Psychosocial approaches are holistic and history 'from below' has uncovered the perspective of patients or sufferers: what MH professionals now term 'service users'. How did patients experience asylums and psychiatry? What were their life stories rather than just medical histories? Online collections of modern patients' oral testimonies and service user forums alike tend to emphasize the negative aspects of psychiatry inside and outside hospitals. Offering a narrative of compulsion and confinement, groups may term their members 'survivors'. Hyperbolic headlines meanwhile talk of 'living hells'. When we look at the documentary record in patient letters (or, more recently, the spoken one) we see instead a spectrum of experiences. Some patients accepted they had been ill and were grateful to nurses and doctors, seeing asylums as therapeutic communities that were truly 'places of refuge'. Others were dominated by painful memories of detention, degradation, and treatment, forced on them for no good reason. But respondents were most often ambivalent, the meanings of the asylum contested and fluctuating over time and space.[48]

Historians can sometimes get close enough to feel the complex texture of practitioner-patient relations. Some medical professionals were arrogant and even abusive, but most seem to have done their best to help sufferers, while recognising the fragilities of their charges. Admitted to Perth Prison's Criminal Lunatic Department after murdering her young child in 1867, Margaret H went through multiple conditional discharges from the 1870s. She petitioned, with feeling, for release, but always suffered relapses. For their part, resident and visiting doctors were keen to free her. Liberated on 18 January 1889 she was readmitted just two days later. The medical superintendent annotated her case notes, with feeling, 'This poor woman seems only to be sane in confinement.'[49] She ended her days in a general lunatic asylum.

Patients were seldom abandoned in asylums if there was always a family member or an official to monitor their progress. Formal advocacy groups started up in Victorian times, such as the Alleged Lunatic's Friend Society (1845-63), and diverse campaigns have spoken out for the disadvantaged ever since.[50] One led to a Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, which reported in 1957, and the Mental Health Act (1959) that came out of it, tweaked ever since. A harder line with authority on human rights sat alongside a gentler one with people when it came to human frailty. The decriminalization of suicide in England and Wales in 1961 came out of the same climate of change, supported even by the Church of England which, while reiterating that suicide was not the correct way to die, espoused intervention and counselling as the best means of prevention.[51]

Patient associations, on the other hand, are much more recent, their emergence reflecting transformations beyond medicine and the asylum.[52] From the 1950s onwards radical social, economic, and political formations demanded a very different kind of mental medicine. The result of this groundswell was a potent - if unlikely - combination of four influences: liberalism, libertarianism (the principle of freedom from interference), psychiatric reform, and fiscal conservativism. Over the course of a generation these drove both deinstitutionalization and a shift in the balance of power between patients and practitioners. Yet service user involvement continues to vary substantially over space because of political history and political choice. The island of Ireland is an example. The Irish Republic brought service users actively to the centre of designing provision in the 2000s, a

path MH services in Northern Ireland have only begun to tread since devolution in 1998 reduced the centralised power of civil servants over patients and local communities.[53]

Patient accounts of their experience of mental problems and of 'service use' have been around since the 17th century, but have only begun to be interpreted by historians as something more than curiosities during the last generation.[54] Most were written by social elites.[55] A rare autobiographical account by a working-class woman illustrates the problems in reading patient accounts and recovering their 'voices' in the different climate of thought changing ideologies have created. Christian Watt's retrospective description of the reasons for her institutionalization at Aberdeen Royal Mental Asylum in 1877 is thoughtful, dignified, articulate, and seemingly open. The papers accompanying her admission, in contrast, paint a more disturbing picture of her state of mind. The certifying doctor found her to be 'in a state of great excitement, violent, and incoherent in her talk ... [and] labours also under delusions of a religious nature … She poured several bottles of paraffin bought especially for the purpose over the floor of her house and set fire to it. She also anointed a hen with paraffin and roasted it alive "for a sacrifice" and wished to offer up her son'.[56]

Because we are the products of the fundamental social and ideological changes of the mid-20th century, modern readers of such accounts tend to be less critical of people who seem oppressed – in Christian's case female, working class, poor, and allegedly insane - and so we privilege their voices as somehow more 'authentic' than others. We may excuse omissions because she forgot, or preferred to forget, how disturbed she was, or been reluctant to recount some of the potentially embarrassing details. In contrast, we tend to be sceptical about the claims of those who seem to have positions of authority to defend. Perhaps it is best to stand back from both types of account, comparing them and looking at the context in which they were made, to create a complete picture. That is what historians do best.[57]

Prospects

What does the evidence show about the development of psychiatry and especially the reasons behind, and the experience of the trajectory from extra- to intra-mural care and back again? By allowing a more evidence-based, bottom-up approach to history, we can understand better psychiatry and its ideological and cultural context. Knowing the past and

shaping the future are not separate projects if we remember that we are all migrants through time. Decisions clinicians and others make bring modern values to the past, but understandings of the past also inform present and future actions; we are all its products. It is only in the last generation that evidence-based scientific research has been at the core of policy and provision of MH care, though ideological stances continue to trump science, society, and even economics. In their introduction to the history of RCPsych, Berrios and Freeman distance themselves from those who have sought to revise the traditional narrative of psychiatric progress; they claim that medicine's place in society is 'mainly instrumental'.[58] But if the historiography of psychiatry is not value-free and nor is its actual history, does the evidence really allow us to say that the practice of psychiatry in the present day is not influenced by subjective values or standards from outside medicine?

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